STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		005038	B. WING		02/1	1/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN HOSPITAL	520 S 7TH VINCENNI	ST ES, IN 47591			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS		S 000			
	This visit was for the i complaint.	investigation of one (1) State				
	Complaint Number: IN00159661 Substantiated; State of allegations are cited. deficiency cited.	deficiencies related to the One (1) unrelated				
	Date of survey: 2/11/	15				
	Facility number: 00	05038				
	Surveyor: Jennifer Hembree RN Public Health Nurse S					
	QA: claughlin 03/12/	15				
S 732	410 IAC 15-1.5-4 ME SERVICES	DICAL RECORD	S 732			4/9/15
	410 IAC 15-1.5-4(d)(1	1)(2)(3)(4)				
	(d) The medical recorsufficient information					
	(1) identify the patien(2) support the diagn(3) justify the treatme(4) document accura of treatment and	osis; ent; and tely the course				
	nursing staff failed to	t as evidenced by: eview and interview, the accurately document patient ents (patients #5 and #6).				

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SU COMPLET		
		005038	B. WING		02/11	/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		520 S 7		•		
GOOD SA	MARITAN HOSPITAL		NES, IN 47591			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 732		e 1	S 732			
	Findings include;					
	NORMALS" with app page 1: "2. Charting implemented by all cl defined classification below:f. Musc tenderness in joints. Ambulation/movements	NTATION SYSTEM: BY EXCEPTION, PATIENT roval date of 12/11 states on a by exception will be narting clinicians using the normal as listed uloskeletal- No swelling or No muscle weakness. In appropriate to age. or age. Full weight bearing				
	medical record indication (A) Nursing documer complained of pain by 10/26/14. The pain at hip. Complaints of pathours were in the left lacked documentation that an assessment vinjury, or that the phy patient's complaint. (B) The patient was medical/surgical unit Per the H&P for the redictated on 10/26/14, severe hip pain and rordered and revealed.	ntation indicated the patient eginning at 0238 hours on at that time was in the right ain on 10/26/14 at 1005 hip. The medical record of any event that occurred, was performed to rule out sician was notified of the transferred to the at 12:30 p.m. on 10/26/14.				

Indiana State Department of Health

STATE FORM 6899 WHLV11 If continuation sheet 2 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		005038	B. WING		02/1	1/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE			
GOOD SA	MARITAN HOSPITAL	520 S 7TH VINCENNE	I ST ES, IN 47591				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
S 732	Continued From page	2 2	S 732				
	 4. Patient #6 medical record lacked documentation of a fall during his/her stay on the Behavioral Health Unit (BHU) 12/15/14 through 12/24/14. 5. Review of incident reports filtered for the 						
	Behavioral Health Unit (BHU) for October-December 2014 indicated the following: (A) An incident report was completed for patient #5 indicating he/she complained of pain upon arrival to the medical/surgical unit. The patient was not transferred from the wheelchair to the bed due to the complaint and was sent for an x-ray. (B) An incident report was completed for patient #6 indicating he/she had a fall at 5:31 a.m. on 12/22/14. The incident report indicated that the						
	6. Document titled "Findicated that patient 12/22/14. The document titled "Findicated that patient to the following property in the following property is a second to the following property i	Post Fall Conference" #6 had a fall at 5:30 a.m. on ment indicated that the the floor in the middle of the					
	indicated in interview 2/11/15 that documen Conference" was not and that there was not the medical record for in email dated 2/13/15 events related to patic 10/25/14 in which he/able to bear weight with medical record.	Chief Administrative Officer) beginning at 3:30 p.m. on it titled "Post Fall part of the medical record of documentation of a fall in ir patient #6. He/she verified 5 at 11:14 a.m. that the ent #5 on night shift of she hit the sink and was not were not documented in the Registered Nurse- Nursing					

Indiana State Department of Health

STATE FORM 6899 WHLV11 If continuation sheet 3 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED				
		005038	B. WING	B. WING		2/11/2015			
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STAT	E ZIP CODE	•				
	520 S 7TH ST								
GOOD SA	MARITAN HOSPITAL		IES, IN 47591						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE			
S 732	3:55 p.m. on 2/11/15 the medical record. 9. Staff member #6 (PNT) indicated in pho 6:13 p.m. on 2/11/15 with patient #5 who wa fractured hip. He/sl when patient #5 woke up in bed and said "guthe bathroom before I there and the patient He/she opened the bapatient was attemptin The patient was leani hip into the corner of hit the sink hard and on helped the patient to suse the bathroom. All leaned forward and at the emergency buttor stood the patient up with #8 (RN) and the patient was of pain. The events in reported to the nurses bed.	in interview beginning at that falls are documented in Psychiatric Nursing Techne interview beginning at that he/she was sitting 1:1 as later discovered to have ne was sitting in the hall from a dead sleep, popped otta go". The patient got to ne/she could get up and get shut the bathroom door. athroom door and the g to pull down his/her pants. Ing to the left and "ran" left the sink. The patient did not did not complain. He/she sit down and the patient did I of a sudden, the patient cted "out of it". He/she hit if for the nurses. He/she with the help of staff member int could not bear weight. The could not move. Later in bed, he/she complained	S 732						
	interview beginning a he/she was in charge nights 10/25/14. Patimember #6 was with light came on and he/reported that patient # jumped up and went the patient acted like	t 11:55 a.m. on 2/12/15 that of charting for patient #5 on ent #5 was a 1:1 and staff the patient. The emergency she responded. It was #5 had been impulsive and to the bathroom and then he/she could not stand from							

Indiana State Department of Health

STATE FORM 6899 WHLV11 If continuation sheet 4 of 8

(X3) DATE SURVEY

Indiana State Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

			
005038	B. WING		02/11/2015
GOOD SAMARITAN HOSPITAL 520 S	T ADDRESS, CITY, STATE 7TH ST ENNES, IN 47591	, ZIP CODE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)	
and staff put the patient to bed. He/she assessed the patient and found no rotation or shortening of leg. Stated "there was nothing." He/she assessed the patient throughout the night and the patient complained of his/her whole leg hurting. Staff member #6 did tell him/her about patient hitting the sink, however he/she is not sure when. He/she called the physician to report. Indicated that patient #5 normally would get up and was very impulsive. When asked about charting of the events in the bathroom, the patient's inability to stand and pain, he/she indicated that they had charted it stating "I thought I charted it" and "I was sure I charted it." S 912 410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting	S 732		4/9/15

(X2) MULTIPLE CONSTRUCTION

Indiana State Department of Health

STATE FORM 6899 WHLV11 If continuation sheet 5 of 8

REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S 912 Continued From page 5 responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S 912 Continued From page 5 responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service				
GOOD SAMARITAN HOSPITAL X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE		005038	B. WING	02/11/2015
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S 912 Continued From page 5 responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service	NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, ZIP CODE	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S 912 Continued From page 5 responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service	GOOD SAMARITAN HOSPITAL			
responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service	PREFIX (EACH DEFICIEN	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE	SHOULD BE COMPLETE
requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital. This RULE is not met as evidenced by: Based on document review and interview, the nurse executive failed to ensure nursing staff followed facility policy related to incident reports for 1 of 7 patients (patient #5). Findings include; 1. Facility policy titled "COMPUTERIZED INCIDENT REPORTING PROCESS GUIDELINES" last reviewed/revised 7/14 states on page 1: "A computerized incident occurrence form will be completed within the shift, whenever there is an occurrence involving a patient, visitor, volunteer, or employee that is not consistent with the accepted routine operation of the hospital or the routine care of a particular patient, or is an unusual or unexpected response by a patient to standard treatment or medical intervention." 2. Review of incident reports filtered for the Behavioral Health Unit (BHU) for October-December 2014 indicated the following: (A) There was no incident report completed for patient #5 involving hitting the bathroom sink with a change in mobility satus after the event.	responsibilities for a positions. (iv) Ensuring that all personnel meet ann requirements as est hospital and medical procedure, and federequirements. (v) Establishing the nursing care and prosettings in which nulprovided in the hospital and document nurse executive failed followed facility policy for 1 of 7 patients (promoted in the followed facility policy titled followe	rsing staff rsing in-service shed by aff policy and and state Indards of the in all grare is Inservice shed by: riew and interview, the reports filtered for the ricular patient, or is an response by a patient to ricular patient, or is an response by a patient to redical intervention." Reports filtered for the report completed for right had bathroom sink with		

Indiana State Department of Health

STATE FORM 6899 WHLV11 If continuation sheet 6 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		IED
		005038	B. WING		02/1	1/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		520 S 7TH	ST			
GOOD SA	MARITAN HOSPITAL	VINCENNE	S, IN 47591			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
S 912	Continued From page	÷ 6	S 912			
	the following: (A) Nursing documer complained of pain be 10/26/14. The pain a hip. Complaints of pain be hours were in the left 4. Staff member #6 (Tech-PNT) indicated at 6:13 p.m. on 2/11/1 with patient #5 who wa fractured hip. He/sl when patient #5 woke up in bed and said "githe bathroom before I there and the patient He/she opened the bapatient was attemptin The patient was leanihip into the corner of hit the sink hard and chelped the patient to use the bathroom. Alleaned forward and at the emergency buttor stood the patient up w #8 (RN) and the patient was of pain. The events in	Psychiatric Nursing in phone interview beginning 15 that he/she was sitting 1:1 ras later discovered to have the was sitting in the hall at from a dead sleep, popped otta go". The patient got to the/she could get up and get shut the bathroom door. The patient got to the left and "ran" left the sink. The patient did not complain. He/she sit down and the patient did I of a sudden, the patient cted "out of it". He/she hit in for the nurses. He/she with the help of staff member and could not move. Later in bed, he/she complained				
	interview beginning a he/she was in charge nights 10/25/14. Pati	RN) indicated in phone t 11:55 a.m. on 2/12/15 that of charting for patient #5 on ent #5 was a 1:1 and staff the patient. The emergency				

Indiana State Department of Health

STATE FORM 6899 WHLV11 If continuation sheet 7 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		005038	B. WING		02/1	1/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOOD SA	MARITAN HOSPITAL	520 S 7TH S VINCENNE	ST S, IN 47591			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
S 912	light came on and her reported that patient is jumped up and went the patient acted like the commode. An ordand staff put the patient and found leg. Stated "there was assessed the patient patient complained of Staff member #6 did to the patient and staff member #6 did to the patient complained of Staff member #6 did to the patien	/she responded. It was #5 had been impulsive and to the bathroom and then he/she could not stand from derly lifted the patient up ent to bed. He/she assessed no rotation or shortening of	S 912			

Indiana State Department of Health